MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 9, 2004
10:36 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM

Mandated report on benefits design and cost sharing in Medicare Advantage plans

-- Rachel Schmidt, Jill Bernstein

DR. SCHMIDT: Good morning. Jill and I are going to present some of the work underway for a study that MedPAC was mandated to complete under the Medicare Modernization Act. Although they are not sitting up here at the table with us, Susanne Seagrave and Sarah Kwon were also very instrumental to the analysis that we're going to show you today.

Here's some of the actual language from the mandate. It specifically asked us to look at benefit structures in Medicare Advantage plans to determine whether cost-sharing requirements are affecting access to care or being used to select enrollees on the basis of health status. We're looking to see whether there are observable biases in the cost-sharing requirements of some plans. For example, relatively higher cost-sharing for dialysis services or radiation therapy.

We're also to report on whether such behavior is widespread. And if so, how the Medicare program might address it. This report is due at the end of the calendar year and the Commission is to provide recommendations if you think it is appropriate.

This is our first presentation about this topic and we're about midway through the analysis. As with a lot of MedPAC research, we're bringing you the results in pieces, so please keep in mind that there is still more of this to come.

Recall that the mandate asked about access to care and evidence of using cost-sharing to select enrollees. To get at those questions, we're using several research approaches that are shown on this slide. Those that are highlighted are steps that are farther along and some of which you'll hear about today. In particular, I will describe the findings of an expert panel that MedPAC staff convened last March for this study, and Jill will present some of the preliminary results from our analysis of plan benefit packages.

At another meeting this fall we'll also present to you analysis of plan risk scores, a look at survey data on why beneficiaries disenroll from fall from Medicare Advantage plans and some comparisons of how out-of-pocket spending can vary among MA plans in the same market area for a few categories of prototypical beneficiaries.

Let's review the current process that CMS uses to approve proposed plans. Generally, plans have broad flexibility to design their benefit packages so long as they meet certain requirements, such as including all services covered by Parts A and B, and returning payments above allowable cost to beneficiaries, usually through extra benefits or lower Part B premiums.

CMS starts by issuing guidance for plan proposals in the

spring of each year. Since 2002, CMS has included guidelines for cost-sharing because of concerns about beneficiary liability for dialysis, chemotherapy and other services like inpatient stays. Managed care organizations then submit their plan adjusted community rate proposals, made up of their proposed benefit package and premiums. CMS reviews and approves or disapproves all of that information for coordinated care plans. They must also review and approve private fee-for-service and medical savings account proposals, but their premiums are not subject to review or approval.

When reviewing a plan's proposed cost-sharing, CMS wants to ensure that the combination of basic premiums and cost-sharing is actuarially equivalent to, or more generous than, fee-for-service Medicare's cost-sharing, which is estimated to be about $113 per month for 2004. And also that the proposal doesn't discriminate, discourage enrollment, or hasten disenrollment on the basis of health status.

Notice that you can meet actuarial equivalence to fee-for-service cost-sharing and still have some cost-sharing for particular services that is relatively high since CMS is comparing overall average amounts of cost-sharing. To evaluate discriminatory behavior, CMS looks to see that cost-sharing for individual services is no higher than what it would be in fee-for-service, although it does allow higher cost-sharing in some cases. It also looks to see whether cost-sharing for some services is higher than the plan's general level of cost-sharing.

CMS has said in recent years that it thinks that increases it has seen for cost-sharing for services like chemo and dialysis are of concern to it. It suggests that plans adopt a cap on out-of-pocket spending, which is set at $2,560 in 2004. If plans adopt that cap, CMS says it will allow them more latitude in setting cost-sharing for individual services.

There are a number of changes underway to the Medicare Advantage program that may affect the mix of enrollees and plans, and it's not yet clear what the net effects of all of these changes will be. Let's review a few of them.

CMS's new risk adjusters will be fully phased in by 2007, which should provide larger payments to plans for enrolling sicker beneficiaries. Beginning in 2006, local or county-level Medicare Advantage plans may begin competing with regional or multi-county Medicare Advantage plans. These regional PPOs must use a combined deductible and an out-of-pocket cap in their benefits design.

For some beneficiaries, outpatient drug benefits have been a particular reason to enroll in Medicare Advantage plans. Beginning in 2006, MA plans will be competing with stand-alone drug plans to administer the new Part D drug benefit.

Also in 2006, CMS will move from the adjusted community rate proposal process to one where plans bid their price for delivering a benefit package based on fee-for-service cost-sharing or cost-sharing that is actuarially equivalent to it. If the plan's bid is less than the benchmark payment amount, in most cases 75 percent of that is to be rebated to enrollees in the form of supplemental benefits or lower Part B or Part D premiums, and 25 percent will be returned to the trust funds. This may

constrain the ability of plans to use cost-sharing that is as generous as some plans offer today.

The MMA gives CMS authority to negotiate with most types of plans, with the exception of private fee-for-service and MSAs over their bids, similar to the authority that the Office of Personnel Management has for administering the Federal Employees Health Benefits Program. This includes authority to negotiate plan federal cost-sharing requirements.

Now let's turn to some of the findings of an expert panel that MedPAC staff convened last March. That panel consisted of 15 people representing beneficiary advocates, academics, private plans, and consulting actuaries to employers. The panel agreed that there's quite a bit of variation in cost-sharing requirements among plans that are competing within the same market area. They thought there was even more variation across plans, primarily because of differences in payment rates, but still considerable variation within markets.

The general consensus seemed to be that cost-sharing requirements were not affecting access to care of plan enrollees in a widespread manner. But many of the panelists were aware of certain plans that had put relatively high cost-sharing in place for some services such as chemotherapy.

There was also general consensus that variation in cost-sharing among competing plans can be confusing to beneficiaries and make comparisons difficult. CMS has tools, such as the web-based personal plan finder, to help beneficiaries compare their options. Nevertheless, plan cost-sharing can differ quite a bit across many different dimensions, so it can be hard for a beneficiary to understand the financial implications of their options.

One panelist described plans that continue to use 20 percent coinsurance on chemotherapy with lower cost-sharing on more routine services and no out-of-pocket cap. Even though a cancer patient without supplemental coverage would face the same cost-sharing under fee-for-service Medicare, the panelists thought that plans should protect sick enrollees from such high cost-sharing. Other panelists thought that such a comparison was unfair, that MA plans shouldn't be held to a different standard than fee-for-service, which can have open-ended cost-sharing liability.

There was no consensus among the panelists on whether Medicare should use a standardized benefit for MA plans. Some thought it would make comparisons easier for beneficiaries and might promote competition more on the basis of premiums and networks rather than premiums, networks, and benefits and cost-sharing. Other panelists thought that beneficiaries are better off when they can find a plan that best suits their individual needs.

Panelists agreed on the importance of providing beneficiaries with information about their plan options that is easy to understand so that they can evaluate their choices clearly.

DR. BERNSTEIN: To provide a sense of what cost-sharing looks like across the plans we examined data submitted by the plans to CMS's plan benefit package file, the PBP file. A subset

of that information is used in the Medicare personal plan finder that's available to beneficiaries on the Internet. Whether beneficiaries are able to sort through these data successfully is one of the issues we may want to come back to when we talk more about whether cost-sharing affects beneficiary decisions about enrollment or disenrollment.

We used individual plans as the unit of analysis because a variety of plans with different benefit structures may be offered by the same market by a single parent group. In this analysis we omitted plans that are not actively enrolling beneficiaries from the community, including special plans and demonstrations like S-HMO or PACE. We also did not look at employer-only plans. We estimated the enrollment in the plans by using the projected enrollment figures submitted by the plans in their ACR proposals. The plans we included account for over 90 percent of Medicare enrollment.

This is an excerpt taken directly from the personal plan finder on the Web. It's one section of a chart that compares three plans in one county. Section one, which shows the plan premiums and, if the plan has a cap, the out-of-pocket cap that covers Medicare-covered services is listed in this section with the services that fall under the cap. I'm shoring it because it shows you first that some plans have caps and some don't, and how a cap might work.

In plan one there's a cap that's set at $3,500. The other two plans do not have a cap. Plan one's cap lists 25 distinct Medicare-covered services that fall under its out-of-pocket cap.

Second this chart illustrates that the available details on cost-sharing still leave some holes because you don't know what's not there. For example, there's no information here on Part B drugs. In this case, plan one does not list Part B drugs as falling under its cap because it does not require cost-sharing for Part B drugs. But that information is nowhere on the plan finder, either under the Medicare-covered services descriptions or in the description of the plan's prescription drug benefit. There's no information on cost-sharing for Part B drugs for the other plans either. One of these has no cost-sharing for Part B drugs, the other charges 20 percent cost-sharing for Part B drugs.

In this little excerpt here we see information on radiation therapy across these plans. One charges $25 per treatment, the second is $40, the third is 20 percent coinsurance. Beneficiaries may find it particularly difficult to estimate their costs in plan three because they don't know it's 20 percent of what. The out-of-pocket cost for radiation therapy is not included on a list of services covered by plan one's cap.

Let's talk about caps just for second. Cost-sharing involves an interaction between out-of-pocket caps and cost-sharing requirements for specific services. This chart shows that about half of the plans enrolling about half of beneficiaries in MA plans altogether have some sort of an out-of-pocket cap. About 30 percent of the plans have a cap on out-of-pocket costs that apply to some, most, or all Medicare-covered services, another 18 percent that apply only to cost for inpatient hospital care. The amounts covered by the caps vary

from plan to plan. The median size of the caps is $2,560, the level suggested by CMS in its letter, and the other caps generally cluster around that figure. Some, however, are considerably higher, $4,000 or more.

DR. NELSON: Can I ask a question at this point? It would be helpful for me to know whether the plans are talking about the same out-of-pocket costs. That is, are they all talking about coinsurance plus deductibles plus copayments? Or are some talking about just coinsurance and not the others? And what are we talking about when we are talking about capping out-of-pocket costs?

DR. BERNSTEIN: Most of the plans include the cost for deductibles and coinsurance for the specified Medicare-covered services that is unique to that -- it's different from plan to plan. So in plan one that we were looking at before, most of cost-sharing is copayments, and those are included -- if they are for services listed in that column, they apply to that. In other plans there's 20 percent across-the-board coinsurance for most services. And if those plans have a cap, the 20 percent applies there. In some plans there's a combination of coinsurance and copayments, and some are included in the Medicare cap and some are not.

There's no way to -- it's almost unique to plans. But we've tried to get as much as we could -- in every table or chart we tried to figure out what was included and what wasn't, because they code them separately, so we added them.

DR. SCHMIDT: But we are talking about the combination of all kinds of cost-sharing, so copayments, coinsurance, but not premiums.

DR. BERNSTEIN: But they may be counted differently in different plans is the complication.

In the plans that only have caps on hospital-covered services, those caps range from $200 to about $2,500. As we mentioned briefly, inpatient costs for hospital care also vary a lot among the plans, from zero to as much as $400 per day for some number of days.

But caps are only one part of the story. Some plans have very little cost-sharing but have caps, and some don't have caps. Some plans with relatively high cost-sharing have caps and others don't have caps. To understand how all this works, we're going to look at just a few of the services that we've mentioned briefly.

The first is Part B drugs, and this is the hardest. According to the plan benefit file data, about 18 percent of MA plans and a similar percentage of enrollees, are in plans that say they do not impose any cost-sharing for Medicare-covered Part B drugs. Most, however, require either copayments, coinsurance, or some combination of the two, usually based on where the drug sits in their formulary or other criteria. About 30 percent of the plans report that they require a copayment for Part B drugs, which is not shown on this chart. Most of the copays were in the $100 range, some were somewhat larger than that.

Coinsurance requirements are more common in the plans. As the chart shows, most of the plans that have coinsurance require coinsurance at the rate of 20 percent for Medicare-covered drugs.

However, after calling a number of plans and talking to people who actually code their plan's data we confirmed our suspicions that there are some inconsistencies in the way that the information was reported in the plan benefit file data, especially when it comes to physician-administered drugs provided in office settings.

Some plans, for example, consider physician-administered drugs as part of the office visit and do not code coinsurance or copayment information on the PBP file. Cost-sharing for office-based drugs may be determined by individual plans reflecting negotiations with network physicians. There's additional information on how all of this works that an individual beneficiary can get from the printed explanation of benefits brochure that their plan supplies. But even that is not going to give them information on how specific drugs might be charged.

So the bottom line is that neither we nor CMS have data that will tell us answers to questions that we would like to be able to answer. This chart should therefore be viewed as a ballpark estimate of what cost-sharing for Part B drugs also looks like. The takeaway messages are, first, there's a lot of variation in coinsurance and copayments and cost-sharing for Part B drugs; and two, this is hard for anybody, CMS, beneficiaries, or us to figure out.

The next two charts are easier. These show radiation therapy and dialysis services. The distribution of cost-sharing among the plans is similar; about one-fifth of the plans do require some kind of coinsurance at 20 percent. The PBP file indicates that the plans charging 20 percent for radiation therapy for the most part do not have caps on that spending. For dialysis, about half the plans charging coinsurance do cap beneficiary costs. Some plans also charge flat copayments for radiation therapy; also not reflected in this chart. The plan finder information also tells beneficiaries that they may be charged additional facility fees by some plans or under some circumstances.

DME services as a whole are of concern to the plans and to CMS because of high levels of utilization of some services and continued issues of inappropriate use for some services. In the case of oxygen, however, cost-sharing could impose problems for some beneficiaries. We found that the majority of plans charge 20 percent coinsurance for DME services; more than one-third of plans waive coinsurance for Medicare-covered DME. Most plans that charge coinsurance do not have caps that cover out-of-pocket costs for DME. There's also a couple plans that require 40 percent coinsurance for DME, and these plans do not limit out-of-pocket spending for those services. Those are both private fee-for-service plans. Another private fee-for-service plan charges 30 percent for DME, and that has a cap of total out-of-pocket spending for Medicare-covered services of $5,000.

So in summary, there is considerable difference among plans in cost-sharing, although cost-sharing for most beneficiaries is lower than it would be in fee-for-service Medicare without supplemental insurance for most services. Some plans require as much, or in a small number of cases, more beneficiary cost-sharing for specific services. Some of the services for which

cost-sharing requirements could be of concern are services that are used by beneficiaries with serious health problems, such as inpatient hospital care, Part B drugs, oxygen or radiation therapy.

Understanding the implications of these variations from the perspective of informed beneficiary choice, beneficiaries' cost of care, market competition among plans, et cetera, will require careful consideration. So additional analyses will seek to determine if there's evidence that cost-sharing requirements are a factor in beneficiaries' decisions about disenrolling or joining Medicare plans. We'll also look more closely at the range of out-of-pocket costs for prototypical beneficiaries, and with your input we will try to address the questions posed by the congressional mandate.

DR. SCHMIDT: Thank you.

MR. SMITH: Thank you, that was helpful, if troubling.

Is there any lookback analysis at how well people choose among competing plans. Given their utilization and the structure of the improvisation of costs and coinsurance, how many people make the right choice?

DR. SCHMIDT: I'm not really aware of analyses along those lines. There's some information, for example, from disenrollment survey data that CMS collects to take a look at why people are leaving and that is one thing that we'll be presenting to you in the near future.

DR. REISCHAUER: I cannot resist making a comment on the right choice notion. To do this correctly, the right choice would have to be what you expect your needs to be, as opposed to what they are, and that makes it very complicated.

I enjoyed this paper, but it struck me that there's this terribly complex issue of what is fair or what is acceptable, and looking at all Medicare Advantage plans maybe isn't the right way to do it because we have some which charge supplemental premiums and some that don't. One could argue that those that don't are really providing an alternative to fee-for-service only. So in determining fair or acceptable, we should be comparing the cost-sharing in those plans with fee-for-service only. For those that charge premiums we should do a separate analysis and compare it to fee-for-service plus Medigap, although even that probably isn't totally appropriate because what you are doing in terms of the size of the premiums at least that you mentioned in here is really Medigap light. It's really a premium that's about 30 percent of what the average premium is.

But it would be interesting to see, if you took out those that charge no premium, whether there were fewer bad apples in that pot versus the group as a whole.

DR. BERNSTEIN: Just to clarify that, would that also include -- there are not very many zero premium plans in here. Would you also want us to look at low premium?

DR. REISCHAUER: Because this at the nadir of this. If you had 2004 it would be probably a little different, in many ways. The cost-sharing would be different.

DR. BERNSTEIN: The problem is there are a lot of low premium plans that have very different benefit structures from each other. They don't tend to just be, we cover Medicare-

covered services and we don't charge you an extra premium. It's, we charge you little or no premium, we cover Medicare-covered services with high coinsurance and then give you some extra stuff that Medicare doesn't cover. So we might have three classes rather than two classes of plans.

DR. MILLER: Are we able to look at the premiums?

DR. BERNSTEIN: Yes.

DR. MILLER: Then why don't we think of looking at a distribution to try to address the question.

DR. REISCHAUER: You could do the plans that are clearly charging heavy-duty premium so they should be providing cost-sharing or supplemental benefits that are at least equivalent to fee-for-service plus a Medigap policy, and then the lights, which you are saying there's a lot of, and then the few which charge no premium at all.

DR. MILSTEIN: There is a relationship between the evaluability of this information by seniors and their ability to identify a plan that might have a benefit structure that would indeed give them access to the services they need. Is the relative evaluability of this information by seniors within the scope of what we should comment on? Based on the nods, I'm assuming so.

I would like to, in some ways reiterate my prior comment when we discussed the evaluability of different drug plans. I think for many of us it's the low moment of our year when our parents call us to say, which one should we pick because we can't -- the cognitive burden associated with doing this right exceeds human brainpower. So I think it's an opportunity within this study to comment on this, and I personally would tee up for us the notion that this is not what human brains were ever designed to be able to handle, irrespective of whether you are above or below age 65, and this is what computerized solutions or what the rest of the world uses to try to deal with cognitive burdens of this order of magnitude.

DR. MILLER: Just along those same lines and I think this is the same point. I think as we've going through this, what is actually being reported when we're looking at this also varies along the plans. So even from the agency's point of view, the notion is trying to get what data elements commonly reported so that you can make these judgments. Then I think there is also the concern of how the beneficiary processes the information.

DR. CROSSON: I would like to also compliment you on the paper. I think it is very good and it is an important issue. It seems to me the central point of the problem is the concern about substantial copayments for individuals who are in a position clinically where they have really no discretion about using those services. It gives a lie to the purpose of having coinsurance in the first place one might say.

It also seems from your analysis that it's to some degree limited to a small number of plans. I'm most interested in the issue of the recommended cap. It sounded to me from the comment that CMS has come up with that more or less by taking a mean or a median of the existing caps in the marketplace.

My question is, either mathematically or practically, is there in fact a cap which would make more sense from the

perspective that if the cap was appropriate and provided what appears to be a relative safe harbor, is there a level of a cap which would obviate the problem that we are concerned about and that was listed in the report? The copayments for people with dialysis, or copayments for people with cancer chemotherapy. It seems like there ought to be a relationship between the worst case of those situations and a certain cap. It might not happen to be the mean or the median of what is in the marketplace. If Medicare is going to use that as a safe harbor, more or less aggressive, it would seem to me that it ought to have some science behind it as opposed to just an average of what exists.

MS. RAPHAEL: Two points. We're looking at this very much from the point of view of the plans and their structures. Do we have any information at all on beneficiary out-of-pocket costs for those who are enrolled in plans compared to those in fee-for-service? I know in the past we've looked at that issue.

DR. BERNSTEIN: When we have looked at it in the past, on average, beneficiary out-of-pocket cost for people in MA plans are lower than they are for either employer-sponsored or people who had supplemental insurance. We look at that most years.

MS. RAPHAEL: Is it possible at all to somehow stratify it? I guess building on what Jay was getting at, I thought part of the focus of this was on certain categories of patients who have a particular health status that requires heavy use of certain services that they might be discouraged from using. So is it at all possible to see what the utilization patterns are for those particular categories or what their cost-sharing might be, their out-of-pocket expenditures might be?

DR. SCHMIDT: The data that Jill was referring to are the Medicare current beneficiary survey data. Those are the sorts of comparisons that are available. There is a bit of a lag in those data for some of the comparisons.

But one thing that we will be bringing you in the near future is what I described as cost-sharing among plans for prototypical beneficiaries. So for example, we might take an average, relatively healthy 65-year-old who lives in a certain area and compare the cost-sharing that they would face among certain plans with someone who has colorectal cancer, to bring it home.

MR. HACKBARTH: Rachel, did you have a comment on Jay's?

DR. SCHMIDT: I just wanted to clarify. I don't think that CMS is solely using market information to set its proposed cap levels. It's using a few pieces of information including looking at the percentile of out-of-pocket spending among fee-for-service beneficiaries and trying to take a look at Medigap premiums. That is probably where you're making your comment about looking at averages. So it's not solely looking at the market. That is difficult to do, given that there is imperfect data on Medigap premiums out there. It does try to look at several pieces of information.

DR. REISCHAUER: I would like to build on something that Arnie said and open up a possibility. You have shown us that there's a tremendous amount of variation in the way plans, even within one region, impose cost-sharing. A free marketeer could say, this is maximizing consumer choice. This is wonderful. An

agnostic could say, this is creating a lot of innocent confusion. And somebody who is more cynical might say, there is a lot of malicious misleading going on for marketing purposes.

If you are not in the first camp you quickly get to the point where you say, maybe something should be done to improve the situation that we have now, much like what happened a decade and a half ago with respect to Medigap policies. Should Medicare Advantage plans have 10 standardized cost-sharing regimes which they could choose among so the people would not have 1,000 alternatives bearing on every single dimension, which one does not know, but a more simplified structured set of alternatives which the consumer can more easily understand and compare prices for? And do we want to go there?

DR. SCHMIDT: As I said, in the expert panel the issue came up. Some of the beneficiary advocates in particular argued along the lines, that would be a good idea. I think other panelists thought that would lead to more price competition and that might be a good thing. As I said, there was no consensus on that issue, and some folks pointed out that even in the Medigap world where there are standard policies there is still selection problems.

MR. DURENBERGER: I think Bob asked my question and it goes to this issue of, is it possible to standardize the benefits? Do we have examples in the private world in which employees, for example, are asked to make choices of comparable plans?

DR. SCHMIDT: I think that CalPERS, for example, does use a standard, so there is one example. FEHBP does not, although my understanding is that OPM has used its negotiating authority to make plans more similar than they have been in the past.

DR. MILSTEIN: Standardizing the plans would move in the direction of lowering the cognitive burden associated with assessment. But optimization, if you're trying to coach your mom really also has to do with interacting, even in a non-standardized benefit plan with prior health history and its implications going forward for subsequent demand, which is more of a computerized calculation. That is what modeling software does.

The second point is building on Jay's point. I would be interested in knowing, if it is within the scope of our resources, the degree to which any of this cost-sharing is rooted in available distinctions between discretionary and non-discretionary services. For example, mandatory significant consumer cost-sharing that would apply to a hip fracture has different implications for access and senior health than a tenth return visit within a month for rheumatology, to take an extreme example on the other side. So I would be interested to know whether any of these plans in formulating their cost-sharing structure took into account discretionary versus non-discretionary, close utility, cost-effectiveness, et cetera.

MR. BERTKO: Just to add a bit to the debate on standardized plans, I would alert you that even folks like CalPERS have found a need to move the plan standardizations over periods and that current Medigap I would call obsolete designs, and in this forum with Medicare it might be very difficult to change a formal standard is it didn't, by design, first have at least ranges

within which cost-sharing might change over time.

MR. HACKBARTH: Can I ask a question about the rules that are going to apply under the drug benefit versus these rules? As I understand it, under the drug benefit, specifically with regard to the formulary rules, there is the notion that the formulary ought not to be constructed in a way that is discriminatory towards patients with certain types of clinical problems. Do we have different playing rules for the drug benefit as opposed to this? Arguably, loading on the cost-sharing for chemotherapy would be discriminatory towards patients with cancer.

DR. SCHMIDT: I think this is part of CMS's review and approval process. Bear in mind that things may be changing a bit as we move towards 2006 and there's greater negotiating authority, or not. That remains to be seen how well CMS is able to implement that.

But currently, the process is to review proposed benefit packages, including cost-sharing provisions, and generally look to see whether it's the same sort of cost-sharing across different types of services. So if it were particularly high for chemo and not for others, that would appear discriminatory. CMS, we understand from talking with some people, has in some cases encouraged plans to adopt caps to constrain overall liability. We've also heard from some beneficiary advocates that it has not been so successful in other cases. So I think there's a mixed bag out there.

MR. HACKBARTH: I have been a long-standing advocate of private plans in Medicare, and the core reason for that is I believe that private plans potentially have opportunities to do things creative, beneficial to patients in terms of how they organize care delivery, pay for providers, structure benefits, and the like. So I am very much in favor of giving private plans appropriate flexibility. Whether this particular issue of selective higher cost-sharing, although perhaps not higher than traditional Medicare, the higher cost-sharing on patients with certain types of clinical problems, I'm not sure that that's not beyond the pale of what appropriate flexibility might be.

I would like to second the observations that Jay and Arnie made; the notion of cost-sharing, appropriately applied, is that you apply it to discretionary services, hopefully to alter utilization patterns in an appropriate way. When you're talking about loading it on for chemotherapy, I do not think you're talking about cost-sharing in that sense. So from my perspective the trick here is, we want to allow appropriate flexibility for private plans. That is part of the core principle of having the program of the private plan option. But it seems to me that we ought to be able to draw some boundaries on what appropriate flexibility is. I think this is, from my perspective, getting close to the line.

I also generally favor the notion of some standardization, although with standardization potentially comes some problems if it is not updated appropriately over time.

DR. NELSON: As a matter of principle it seems to me that if we make recommendations with respect to a cap, absent standardization and with the cacophony that is out there in the market, our recommendation ought to be framed in the context of

total out-of-pocket expenses. I do not see any other way to get around the variability in terms of what people have to pay out-of-pocket.

MR. HACKBARTH: Other questions or comments on this topic? Okay, thank you very much. Good job.